

# I

## Part I. Setting the Stage

3rd edition as of August 2022

## Part I. Setting the Stage

Topics Covered:

1. What is Abnormal Psychology?
2. Models of Abnormal Psychology
3. Clinical Assessment, Diagnosis, and Treatment

# Module 1: What is Abnormal Psychology?

3rd edition as of August 2022

## Module Overview

Cassie is an 18-year-old female from suburban Seattle, WA. She was a successful student in high school, graduating valedictorian and obtaining a National Merit Scholarship for her performance on the PSAT during her junior year. She was accepted to a university on the opposite side of the state, where she received additional scholarships giving her a free ride for her entire undergraduate education. Excited to start this new chapter in her life, Cassie's parents begin the 5-hour commute to Pullman, where they will leave their only daughter for the first time in her life.

The semester begins as it always does in mid to late August. Cassie meets the challenge with enthusiasm and does well in her classes for the first few weeks of the semester, as expected. Sometime around Week 6, her friends notice she is despondent, detached, and falling behind in her work. After being asked about her condition, she replies that she is "just a bit homesick," and her friends accept this answer as it is a typical response to leaving home and starting college for many students. A month later, her condition has not improved but worsened. She now regularly shirks her responsibilities around her apartment, in her classes, and on her job. Cassie does not hang out with friends like she did when she first arrived for college and stays in bed most of the day. Concerned, Cassie's friends contact Health and Wellness for help.

Cassie's story, though hypothetical, is true of many Freshmen leaving home for the first time to earn a higher education, whether in rural Washington state or urban areas such as Chicago and Dallas. Most students recover from this depression and go on to be functional members of their collegiate environment and accomplished scholars. Some students learn to cope on their own while others seek assistance from their university's health and wellness center or from friends who have already been through the same ordeal. These are normal reactions. However, in cases like Cassie's, the path to recovery is not as clear. Instead of learning how to cope, their depression increases until it reaches clinical levels and becomes an impediment to success in multiple domains of life such as home, work, school, and social circles.

In Module 1, we will explore what it means to display abnormal behavior, what mental disorders are, and the way society views mental illness today and how it has been regarded throughout history. Then we will review research methods used by psychologists in general and how they are adapted to study abnormal behavior/mental disorders. We will conclude with an overview of what mental health professionals do.

## Module Outline

- [1.1. Understanding Abnormal Behavior](#)
- [1.2. Classifying Mental Disorders](#)
- [1.3. The Stigma of Mental Illness](#)

- [1.4. The History of Mental Illness](#)
- [1.5. Research Methods in Psychopathology](#)
- [1.6. Mental Health Professionals, Societies, and Journals](#)

## Module Learning Outcomes

- Explain what it means to display abnormal behavior.
- Clarify how mental health professionals classify mental disorders.
- Describe the effect of stigma on those who have a mental illness.
- Outline the history of mental illness.
- Describe the research methods used to study abnormal behavior and mental illness.
- Identify types of mental health professionals, societies they may join, and journals they can publish their work in.

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# 1.1. Understanding Abnormal Behavior

## Section Learning Objectives

- Describe the disease model and its impact on the field of psychology throughout history.
- Describe positive psychology.
- Define abnormal behavior.
- Explain the concept of dysfunction as it relates to mental illness.
- Explain the concept of distress as it relates to mental illness.
- Explain the concept of deviance as it relates to mental illness.
- Explain the concept of dangerousness as it relates to mental illness.
- Define culture and social norms.
- Clarify the cost of mental illness on society.
- Define abnormal psychology, psychopathology, and mental disorders.

### 1.1.1. Understanding Abnormal Behavior

To understand what abnormal behavior is, we first have to understand what normal behavior is. *Normal* really is in the eye of the beholder, and most psychologists have found it easier to explain what is wrong with people than what is right. How so?

Psychology worked with the disease model for over 60 years, from about the late 1800s into the middle part of the 20th century. The focus was simple – curing mental disorders – and included such pioneers as Freud, Adler, Klein, Jung, and Erickson. These names are synonymous with the psychoanalytical school of thought. In the 1930s, behaviorism, under B.F. Skinner, presented a new view of human

behavior. Simply, human behavior could be modified if the correct combination of reinforcements and punishments were used. This viewpoint espoused the dominant worldview of the time – mechanism – which presented the world as a great machine explained through the principles of physics and chemistry. In it, human beings serve as smaller machines in the larger machine of the universe.

Moving into the mid to late 1900s, we developed a more scientific investigation of mental illness, which allowed us to examine the roles of both nature and nurture and to develop drug and psychological treatments to “make miserable people less miserable.” Though this was an improvement, there were three consequences as pointed out by Martin Seligman in his 2008 TED Talk entitled, “The new era of positive psychology.” These are:

- “The first was moral; that psychologists and psychiatrists became victimologists, pathologizers; that our view of human nature was that if you were in trouble, bricks fell on you. And we forgot that people made choices and decisions. We forgot responsibility. That was the first cost.”
- “The second cost was that we forgot about you people. We forgot about improving normal lives. We forgot about a mission to make relatively untroubled people happier, more fulfilled, more productive. And “genius,” “high-talent,” became a dirty word. No one works on that.”
- “And the third problem about the disease model is, in our rush to do something about people in trouble, in our rush to do something about repairing damage, it never occurred to us to develop interventions to make people happier — positive interventions.”

Starting in the 1960s, figures such as Abraham Maslow and Carl Rogers sought to overcome the limitations of psychoanalysis and behaviorism by establishing a “third force” psychology, also known as humanistic psychology. As Maslow said,

“The science of psychology has been far more successful on the negative than on the positive side; it has revealed to us much about man’s shortcomings, his illnesses, his sins, but little about his potentialities, his virtues, his achievable aspirations, or his full psychological height. It is as if psychology had voluntarily restricted itself to only half its rightful jurisdiction, and that the darker, meaner half.” (Maslow, 1954, p. 354).

Humanistic psychology instead addressed the full range of human functioning and focused on personal fulfillment, valuing feelings over intellect, hedonism, a belief in human perfectibility, emphasis on the present, self-disclosure, self-actualization, positive regard, client centered therapy, and the hierarchy of needs. Again, these topics were in stark contrast to much of the work being done in the field of psychology up to and at this time.

In 1996, Martin Seligman became the president of the American Psychological Association (APA) and called for a **positive psychology** or one that had a more positive conception of human potential and nature. Building on Maslow and Roger’s work, he ushered in the scientific study of such topics as happiness, love, hope, optimism, life satisfaction, goal setting, leisure, and subjective well-being. Though positive and humanistic psychology have similarities, their methodology was much different. While humanistic psychology generally relied on qualitative methods, positive psychology utilizes a quantitative approach and aims to help people make the most out of life’s setbacks, relate well to others, find fulfillment in creativity, and find lasting meaning and satisfaction (<https://www.positivepsychologyinstitute.com.au/what-is-positive-psychology>).

So, to understand what normal behavior is, do we look to positive psychology for an indication, or do we first define abnormal behavior and then reverse engineer a definition of what normal is? Our preceding

discussion gave suggestions about what normal behavior is, but could the darker elements of our personality also make up what is normal to some extent? Possibly. **The one truth is that no matter what behavior we display, if taken to the extreme, it can become disordered - whether trying to control others through social influence or helping people in an altruistic fashion.** As such, we can consider **abnormal behavior** to be a combination of personal distress, psychological dysfunction, deviance from social norms, dangerousness to self and others, and costliness to society.

### 1.1.2. How Do We Determine What Abnormal Behavior Is?

In the previous section we showed that what we might consider normal behavior is difficult to define. Equally challenging is understanding what abnormal behavior is, which may be surprising to you. A publication which you will become intimately familiar with throughout this book, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* 5th edition, Text Revision (DSM-5-TR; 2022), states that, "Although no definition can capture all aspects of the range of disorders contained in DSM-5" (pg. 13) certain aspects are required. These include:

- **Dysfunction** - Includes "clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (pg. 14). Abnormal behavior, therefore, has the capacity to make well-being difficult to obtain and can be assessed by looking at an individual's current performance and comparing it to what is expected in general or how the person has performed in the past. As such, a good employee who suddenly demonstrates poor performance may be experiencing an environmental demand leading to stress and ineffective coping mechanisms. Once the demand resolves itself, the person's performance should return to normal according to this principle.
- **Distress** - When the person experiences a disabling condition "in social, occupational, or other important activities" (pg. 14). Distress can take the form of psychological or physical pain, or both concurrently. Alone though, distress is not sufficient enough to describe behavior as abnormal. Why is that? The loss of a loved one would cause even the most "normally" functioning individual pain. An athlete who experiences a career-ending injury would display distress as well. Suffering is part of life and cannot be avoided. And some people who exhibit abnormal behavior are generally positive while doing so.
- **Deviance** - Closer examination of the word *abnormal* indicates a move away from what is normal, or the mean (i.e., what would be considered average and in this case in relation to behavior), and so is behavior that infrequently occurs (sort of an outlier in our data). Our **culture**, or the totality of socially transmitted behaviors, customs, values, technology, attitudes, beliefs, art, and other products that are particular to a group, determines what is normal. Thus, a person is said to be deviant when he or she fails to follow the stated and unstated rules of society, called **social norms**. Social norms change over time due to shifts in accepted values and expectations. For instance, homosexuality was taboo in the U.S. just a few decades ago, but today, it is generally accepted. Likewise, PDAs, or public displays of affection, do not cause a second look by most people unlike the past when these outward expressions of love were restricted to the privacy of one's own house or bedroom. In the U.S., crying is generally seen as a weakness for males. However, if the behavior occurs in the context of a tragedy such as the Vegas mass shooting on October 1, 2017, in which 58 people were killed and about 500 were wounded while attending the Route 91 Harvest Festival, then it is appropriate and understandable. Finally, consider that

statistically deviant behavior is not necessarily negative. Genius is an example of behavior that is not the norm.

Though not part of the DSM conceptualization of what abnormal behavior is, many clinicians add **dangerousness** to this list **when behavior represents a threat to the safety of the person or others**. **It is important to note that having a mental disorder does not imply a person is automatically dangerous**. The depressed or anxious individual is often no more a threat than someone who is not depressed, and as Hiday and Burns (2010) showed, dangerousness is more the exception than the rule. Still, mental health professionals have a duty to report to law enforcement when a mentally disordered individual expresses intent to harm another person or themselves. **It is important to point out that people seen as dangerous are also not automatically mentally ill**.

### 1.1.3. The Costs of Mental Illness

This leads us to wonder what the cost of mental illness is to society. The National Alliance on Mental Illness (NAMI) states that mental illness affects a person's life which then ripples out to the family, community, and world. For instance, **people with serious mental illness are at increased risk for diabetes, cancer, and cardiometabolic disease while 18% of those with a mental illness also have a substance use disorder**. Within the family, an **estimated 8.4 million Americans provide care to an adult with an emotional or mental illness with caregivers spending about 32 hours a week providing unpaid care**. At the **community level 21% of the homeless also have a serious mental illness while 70% of youth in the juvenile justice system have at least one mental health condition**. And finally, **depression is a leading cause of disability worldwide and depression and anxiety disorders cost the global economy \$1 trillion each year in lost productivity** (Source: NAMI, The Ripple Effect of Mental Illness infographic; <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>).

In terms of worldwide impact, **data from 2010 estimates \$2.5 trillion in global costs, with \$1.7 trillion being indirect costs** (i.e., invisible costs "associated with income losses due to mortality, disability, and care seeking, including lost production due to work absence or early retirement") and the remainder being direct (i.e., visible costs to include "medication, physician visits, psychotherapy sessions, hospitalization," etc.). **It is now projected that mental illness costs will be around \$16 trillion by 2030**. The authors add, **"It should be noted that these calculations did not include costs associated with mental disorders from outside the healthcare system, such as legal costs caused by illicit drug abuse"** (Trautmann, Rehm, & Wittchen, 2016). **The costs for mental illness have also been found to be greater than the combined costs of somatic diseases such as cancer, diabetes, and respiratory disorders** (Whiteford et al., 2013).

Christensen et al. (2020) did **a review of 143 cost-of-illness studies that covered 48 countries and several types of mental illness**. Their results showed that mental disorders are a substantial economic burden for societies and that certain groups of mental disorders are more costly than others. At the higher cost end were developmental disorders to include autism spectrum disorders followed by schizophrenia and intellectual disabilities. They write, **"However, it is important to note that while disorders such as mood, neurotic and substance use disorders were less costly according to societal cost per patient, these disorders are much more prevalent and thus would contribute substantially to the total national cost in a country."** And much like Trautmann, Rehm, & Wittchen (2016) other studies show that indirect costs are higher than direct costs (Jin & Mosweu, 2017; Chong et al., 2016).

### 1.1.4. Defining Key Terms

Our discussion so far has concerned what normal and abnormal behavior is. We saw that the study of normal behavior falls under the providence of positive psychology. Similarly, the scientific study of abnormal behavior, with the intent to be able to predict reliably, explain, diagnose, identify the causes of, and treat maladaptive behavior, is what we refer to as **abnormal psychology**. Abnormal behavior can become pathological and has led to the scientific study of psychological disorders, or **psychopathology**. From our previous discussion we can fashion the following definition of a psychological or mental disorder: **mental disorders** are characterized by psychological dysfunction, which causes physical and/or psychological distress or impaired functioning, and is not an expected behavior according to societal or cultural standards.

### Key Takeaways

You should have learned the following in this section:

- **Abnormal behavior** is a combination of personal distress, psychological dysfunction, deviance from social norms, dangerousness to self and others, and costliness to society.
- **Abnormal psychology** is the scientific study of abnormal behavior, with the intent to be able to predict reliably, explain, diagnose, identify the causes of, and treat maladaptive behavior.
- The study of psychological disorders is called **psychopathology**.
- **Mental disorders** are characterized by psychological dysfunction, which causes physical and/or psychological distress or impaired functioning, and is not an expected behavior according to societal or cultural standards

### Section 1.1 Review Questions

1. What is the disease model and what problems existed with it? What was to overcome its limitations?
2. Can we adequately define normal behavior? What about abnormal behavior?
3. What aspects are part of the American Psychiatric Association's definition of abnormal behavior?
4. How costly is mental illness?
5. What is abnormal psychology?
6. What is psychopathology?
7. How do we define mental disorders?

## 1.2. Classifying Mental Disorders

### Section Learning Objectives

- Define and exemplify classification.
- Define nomenclature.
- Define epidemiology.
- Define the presenting problem and clinical description.
- Differentiate prevalence, incidence, and any subtypes.
- Define comorbidity.
- Define etiology.
- Define course.
- Define prognosis.
- Define treatment.

#### 1.2.1. Classification

Classification is not a foreign concept and as a student you have likely taken at least one biology class that discussed the taxonomic classification system of Kingdom, Phylum, Class, Order, Family, Genus, and Species revolutionized by Swedish botanist, Carl Linnaeus. You probably even learned a witty mnemonic such as ‘King Phillip, Come Out For Goodness Sake’ to keep the order straight. The Library of Congress uses classification to organize and arrange their book collections and includes such categories as B – Philosophy, Psychology, and Religion; H – Social Sciences; N – Fine Arts; Q – Science; R – Medicine; and T – Technology.

Simply, **classification** is how we organize or categorize things. The second author’s wife has been known to color-code her Blu Ray collection by genre, movie title, and release date. It is useful for us to do the same with abnormal behavior, and classification provides us with a **nomenclature**, or naming system, to structure our understanding of mental disorders in a meaningful way. Of course, we want to learn as much as we can about a given disorder so we can understand its cause, predict its future occurrence, and develop ways to treat it.

#### 1.2.2. Determining Occurrence of a Disorder

**Epidemiology** is the scientific study of the frequency and causes of diseases and other health-related states in specific populations such as a school, neighborhood, a city, country, and the world.

**Psychiatric or mental health epidemiology** refers to the occurrence of mental disorders in a population. In mental health facilities, we say that a patient presents with a specific problem, or the **presenting problem**, and we give a **clinical description** of it, which includes information about the thoughts, feelings, and behaviors that constitute that mental disorder. We also seek to gain information about the occurrence of the disorder, its cause, course, and treatment possibilities.

Occurrence can be investigated in several ways. First, **prevalence** is the percentage of people in a

population that has a mental disorder or can be viewed as the number of cases divided by the total number of people in the sample. For instance, if 20 people out of 100 have bipolar disorder, then the prevalence rate is 20%. Prevalence can be measured in several ways:

- **Point prevalence** indicates the proportion of a population that has the characteristic at a specific point in time. In other words, it is the number of active cases.
- **Period prevalence** indicates the proportion of a population that has the characteristic at any point during a given period of time, typically the past year.
- **Lifetime prevalence** indicates the proportion of a population that has had the characteristic at any time during their lives.

According to a 2020 infographic by the National Alliance on Mental Illness (NAMI), for U.S. adults, 1 in 5 experienced a mental illness, 1 in 20 had a serious mental illness, 1 in 15 experienced both a substance use disorder and mental disorder, and over 12 million had serious thoughts of suicide (2020 Mental Health By the Numbers: US Adults infographic). In terms of adolescents aged 12-17, in 2020 1 in 6 experienced a major depressive episode, 3 million had serious thoughts of suicide, and there was a 31% increase in mental health-related emergency department visits. Among U.S. young adults aged 18-25, 1 in 3 experienced a mental illness, 1 in 10 had a serious mental illness, and 3.8 had serious thoughts of suicide (2020 Mental Health By the Numbers: Youth and Young Adults infographic). These numbers would represent period prevalence rates during the pandemic, and for the year 2020. In the, You are Not Alone infographic, NAMI reported the following 12-month prevalence rates for U.S. Adults: 19% having an anxiety disorder, 8% having depression, 4% having PTSD, 3% having bipolar disorder, and 1% having schizophrenia.

Source: <https://www.nami.org/mhstats>

**Incidence** indicates the number of new cases in a population over a specific period. This measure is usually lower since it does not include existing cases as prevalence does. If you wish to know the number of new cases of social phobia during the past year (going from say Aug 21, 2015 to Aug 20, 2016), you would only count cases that began during this time and ignore cases before the start date, even if people are currently afflicted with the mental disorder. Incidence is often studied by medical and public health officials so that causes can be identified, and future cases prevented.

Finally, **comorbidity** describes when two or more mental disorders are occurring at the same time and in the same person. The National Comorbidity Survey Replication (NCS-R) study conducted by the National Institute of Mental Health (NIMH) and published in the June 6, 2005 issue of the Archives of General Psychiatry, sought to discover trends in prevalence, impairment, and service use during the 1990s. The first study, conducted from 1980 to 1985, surveyed 20,000 people from five different geographical regions in the U.S. A second study followed from 1990-1992 and was called the National Comorbidity Survey (NCS). The third study, the NCS-R, used a new nationally representative sample of the U.S. population, and found that 45% of those with one mental disorder met the diagnostic criteria for two or more disorders. The authors also found that the severity of mental illness, in terms of disability, is strongly related to comorbidity, and that substance use disorders often result from disorders such as anxiety and bipolar disorders. The implications of this are significant as services to treat substance abuse and mental disorders are often separate, despite the disorders appearing together.

### 1.2.3. Other Key Factors Related to Mental Disorders

The **etiology** is the cause of the disorder. There may be social, biological, or psychological explanations for the disorder which need to be understood to identify the appropriate treatment. Likewise, the effectiveness of a treatment may give some hint at the cause of the mental disorder. More on this in Module 2.

The **course** of the disorder is its particular pattern. A disorder may be **acute**, meaning that it lasts a short time, or **chronic**, meaning it persists for a long time. It can also be classified as **time-limited**, meaning that recovery will occur after some time regardless of whether any treatment occurs.

**Prognosis** is the anticipated course the mental disorder will take. A key factor in determining the course is age, with some disorders presenting differently in childhood than adulthood.

Finally, we will discuss several treatment strategies in this book in relation to specific disorders, and in a general fashion in Module 3. **Treatment** is any procedure intended to modify abnormal behavior into normal behavior. The person suffering from the mental disorder seeks the assistance of a trained professional to provide some degree of relief over a series of therapy sessions. The trained mental health professional may prescribe medication or utilize psychotherapy to bring about this change. Treatment may be sought from the primary care provider, in an outpatient facility, or through inpatient care or hospitalization at a mental hospital or psychiatric unit of a general hospital. According to NAMI, the average delay between symptom onset and treatment is 11 years with 45% of adults with mental illness, 66% of adults with serious mental illness, and 51% of youth with a mental health condition seeking treatment in a given year. They also report that 50% of white, 49% of lesbian/gay and bisexual, 43% of mixed/multiracial, 34% of Hispanic or Latinx, 33% of black, and 23% of Asian adults with a mental health diagnosis received treatment or counseling in the past year (Source: Mental Health Care Matters infographic, <https://www.nami.org/mhstats>).

## Key Takeaways

You should have learned the following in this section:

- **Classification**, or how we organize or categorize things, provides us with a nomenclature, or naming system, to structure our understanding of mental disorders in a meaningful way.
- **Epidemiology** is the scientific study of the frequency and causes of diseases and other health-related states in specific populations.
- **Prevalence** is the percentage of people in a population that has a mental disorder or can be viewed as the number of cases divided by the total number of people in the sample.
- **Incidence** indicates the number of new cases in a population over a specific period.
- **Comorbidity** describes when two or more mental disorders are occurring at the same time and in the same person.
- The **etiology** is the cause of a disorder while the course is its particular pattern and can be acute, chronic, or time-limited.
- **Prognosis** is the anticipated course the mental disorder will take.

## Section 1.2 Review Questions

1. What is the importance of classification for the study of mental disorders?
2. What information does a clinical description include?
3. In what ways is occurrence investigated?
4. What is the etiology of a mental illness?
5. What is the relationship of course and prognosis to one another?
6. What is treatment and who seeks it?

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## 1.3. The Stigma of Mental Illness

### Section Learning Objectives

- Clarify the importance of social cognition theory in understanding why people do not seek care.
- Define categories and schemas.
- Define stereotypes and heuristics.
- Describe social identity theory and its consequences.
- Differentiate between prejudice and discrimination.
- Contrast implicit and explicit attitudes.
- Explain the concept of stigma and its three forms.
- Define courtesy stigma.
- Describe what the literature shows about stigma.

In the previous section, we discussed the fact that care can be sought out in a variety of ways. The problem is that many people who need care never seek it out. Why is that? We already know that society dictates what is considered abnormal behavior through culture and social norms, and you can likely think of a few implications of that. But to fully understand society's role in why people do not seek care, we need to determine the psychological processes underlying this phenomenon in the individual.

**Social cognition** is the process through which we collect information from the world around us and then interpret it. The collection process occurs through what we know as **sensation** - or detecting physical energy emitted or reflected by physical objects. Detection occurs courtesy of our eyes, ears, nose, skin and mouth; or via vision, hearing, smell, touch, and taste, respectfully. Once collected, the information is relayed to the brain through the neural impulse where it is processed and interpreted, or meaning is added to this raw sensory data which we call **perception**.

One way meaning is added is by taking the information we just detected and using it to assign people to **categories**, or **groups**. For each category, we have a **schema**, or a set of beliefs and expectations about

a group of people, believed to apply to all members of the group, and based on experience. You might think of them as organized ways of making sense of experience. So, it is during our initial interaction with someone that we collect information about them, assign the person to a category for which we have a schema, and then use that to affect how we interact with them. First impressions, called the *primacy effect*, are important because even if we obtain new information that should override an incorrect initial assessment, the initial impression is unlikely to change. We call this the *perseverance effect*, or *belief perseverance*.

**Stereotypes** are special types of schemas that are very simplistic, very strongly held, and not based on firsthand experience. They are **heuristics**, or mental shortcuts, that allow us to assess this collected information very quickly. One piece of information, such as skin color, can be used to assign the person to a schema for which we have a stereotype. This can affect how we think or feel about the person and behave toward them. Again, human beings tend to imply things about an individual solely due to a distinguishing feature and disregard anything inconsistent with the stereotype.

**Social identity theory** (Tajfel, 1982; Turner, 1987) states that people categorize their social world into meaningfully simplistic representations of groups of people. These representations are then organized as *prototypes*, or “fuzzy sets of a relatively limited number of category-defining features that not only define one category but serve to distinguish it from other categories” (Foddy and Hogg, as cited in Foddy et al., 1999). We construct in-groups and out-groups and categorize the self as an in-group member. The self is assimilated into the salient in-group prototype, which indicates what cognitions, affect, and behavior we may exhibit. Stereotyping, out-group homogeneity, in-group/out-group bias, normative behavior, and conformity are all based on self-categorization.

How so? *Out-group homogeneity* occurs when we see all members of an outside group as the same. This leads to a tendency to show favoritism to, and exclude or hold a negative view of, members outside of, one's immediate group, called the *in-group/out-group bias*. The negative view or set of beliefs about a group of people is what we call *prejudice*, and this can result in acting in a way that is negative against a group of people, called *discrimination*. It should be noted that a person can be prejudicial without being discriminatory since most people do not act on their attitudes toward others due to social norms against such behavior. Likewise, a person or institution can be discriminatory without being prejudicial. For example, when a company requires that an applicant have a certain education level or be able to lift 80 pounds as part of typical job responsibilities. Individuals without a degree or ability to lift will be removed from consideration for the job, but this discriminatory act does not mean that the company has negative views of people without degrees or the inability to lift heavy weight. You might even hold a negative view of a specific group of people and not be aware of it. An attitude we are unaware of is called an *implicit attitude*, which stands in contrast to *explicit attitudes*, which are the views within our conscious awareness.

We have spent quite a lot of space and time understanding how people gather information about the world and people around them, process this information, use it to make snap judgements about others, form groups for which stereotypes may exist, and then potentially hold negative views of this group and behave negatively toward them as a result. Just one piece of information can be used to set this series of mental events into motion. Outside of skin color, the label associated with having a mental disorder can be used. Stereotypes about people with a mental disorder can quickly and easily transform into prejudice when people in a society determine the schema to be correct and form negative emotions and evaluations of this group (Eagly & Chaiken, 1993). This, in turn, can lead to discriminatory practices such as an employer refusing to hire, a landlord refusing to rent an apartment, or avoiding a romantic

relationship, all due to the person having a mental illness.

Overlapping with prejudice and discrimination in terms of how people with mental disorders are treated is **stigma**, or when negative stereotyping, labeling, rejection, and loss of status occur. Stigma takes on three forms as described below:

- **Public stigma** - When members of a society endorse negative stereotypes of people with a mental disorder and discriminate against them. They might avoid them altogether, resulting in social isolation. An example is when an employer intentionally does not hire a person because their mental illness is discovered.
- **Label avoidance** -To avoid being labeled as “crazy” or “nuts” people needing care may avoid seeking it altogether or stop care once started. Due to these labels, funding for mental health services could be restricted and instead, physical health services funded.
- **Self-stigma** - When people with mental illnesses internalize the negative stereotypes and prejudice, and in turn, discriminate against themselves. They may experience shame, reduced self-esteem, hopelessness, low self-efficacy, and a reduction in coping mechanisms. An obvious consequence of these potential outcomes is the *why try* effect, or the person saying ‘Why should I try and get that job? I am not worthy of it’ (Corrigan, Larson, & Rusch, 2009; Corrigan, et al., 2016).

Another form of stigma that is worth noting is that of **courtesy stigma** or when stigma affects people associated with a person who has a mental disorder. Karnieli-Miller et al. (2013) found that families of the afflicted were often blamed, rejected, or devalued when others learned that a family member had a serious mental illness (SMI). Due to this, they felt hurt and betrayed, and an important source of social support during a difficult time had disappeared, resulting in greater levels of stress. To cope, some families concealed their relative’s illness, and some parents struggled to decide whether it was their place to disclose their child’s condition. Others fought with the issue of confronting the stigma through attempts at education versus just ignoring it due to not having enough energy or desiring to maintain personal boundaries. There was also a need to understand the responses of others and to attribute it to a lack of knowledge, experience, and/or media coverage. In some cases, the reappraisal allowed family members to feel compassion for others rather than feeling put down or blamed. The authors concluded that each family “develops its own coping strategies which vary according to its personal experiences, values, and extent of other commitments” and that “coping strategies families employ change over-time.”

Other effects of stigma include experiencing work-related discrimination resulting in higher levels of self-stigma and stress (Rusch et al., 2014), higher rates of suicide especially when treatment is not available (Rusch, Zlati, Black, and Thornicroft, 2014; Rihmer & Kiss, 2002), and a decreased likelihood of future help-seeking intention (Lally et al., 2013). The results of the latter study also showed that personal contact with someone with a history of mental illness led to a decreased likelihood of seeking help. This is important because 48% of the university sample stated that they needed help for an emotional or mental health issue during the past year but did not seek help. Similar results have been reported in other studies (Eisenberg, Downs, Golberstein, & Zivin, 2009). It is also important to point out that social distance, a result of stigma, has also been shown to increase throughout the life span, suggesting that anti-stigma campaigns should focus on older people primarily (Schomerus, et al., 2015).

One potentially disturbing trend is that mental health professionals have been shown to hold negative attitudes toward the people they serve. Hansson et al. (2011) found that staff members at an outpatient

clinic in the southern part of Sweden held the most negative attitudes about whether an employer would accept an applicant for work, willingness to date a person who had been hospitalized, and hiring a patient to care for children. Attitudes were stronger when staff treated patients with a psychosis or in inpatient settings. In a similar study,

Martensson, Jacobsson, and Engstrom (2014) found that staff had more positive attitudes towards persons with mental illness if their knowledge of such disorders was less stigmatized; their workplaces were in the county council where they were more likely to encounter patients who recover and return to normal life in society, rather than in municipalities where patients have long-term and recurrent mental illness; and they have or had one close friend with mental health issues.

To help deal with stigma in the mental health community, Papish et al. (2013) investigated the effect of a one-time contact-based educational intervention compared to a four-week mandatory psychiatry course on the stigma of mental illness among medical students at the University of Calgary. The curriculum included two methods requiring contact with people diagnosed with a mental disorder: patient presentations, or two one-hour oral presentations in which patients shared their story of having a mental illness, and “clinical correlations” in which a psychiatrist mentored students while they interacted with patients in either inpatient or outpatient settings. Results showed that medical students held a stigma towards mental illness and that comprehensive medical education reduced this stigma. As the authors stated, “These results suggest that it is possible to create an environment in which medical student attitudes towards mental illness can be shifted in a positive direction.” That said, the level of stigma was still higher for mental illness than it was for the stigmatized physical illness, type 2 diabetes mellitus.

What might happen if mental illness is presented as a treatable condition? McGinty, Goldman, Pescosolido, and Barry (2015) found that portraying schizophrenia, depression, and heroin addiction as untreated and symptomatic increased negative public attitudes towards people with these conditions. Conversely, when the same people were portrayed as successfully treated, the desire for social distance was reduced, there was less willingness to discriminate against them, and belief in treatment effectiveness increased among the public.

Self-stigma has also been shown to affect self-esteem, which then affects hope, which then affects the quality of life among people with severe mental illness. As such, hope should play a central role in recovery (Mashiach-Eizenberg et al., 2013). Narrative Enhancement and Cognitive Therapy (NECT) is an intervention designed to reduce internalized stigma and targets both hope and self-esteem (Yanos et al., 2011). The intervention replaces stigmatizing myths with facts about illness and recovery, which leads to hopefulness and higher levels of self-esteem in clients. This may then reduce susceptibility to internalized stigma.

Stigma leads to health inequities (Hatzenbuehler, Phelan, & Link, 2013), prompting calls for stigma change. Targeting stigma involves two different agendas: The *services agenda* attempts to remove stigma so people can seek mental health services, and the *rights agenda* tries to replace discrimination that “robs people of rightful opportunities with affirming attitudes and behavior” (Corrigan, 2016). The former is successful when there is evidence that people with mental illness are seeking services more or becoming better engaged. The latter is successful when there is an increase in the number of people with mental illnesses in the workforce who are receiving reasonable accommodations. The federal government has tackled this issue with landmark legislation such as the Patient Protection and Affordable Care Act of 2010, Mental Health Parity and Addiction Equity Act of 2008, and the Americans

with Disabilities Act of 1990. However, protections are not uniform across all subgroups due to “1) explicit language about inclusion and exclusion criteria in the statute or implementation rule, 2) vague statutory language that yields variation in the interpretation about which groups qualify for protection, and 3) incentives created by the legislation that affect specific groups differently” (Cummings, Lucas, and Druss, 2013). More on this in Module 15.

## Key Takeaways

You should have learned the following in this section:

- **Stigma** is when negative stereotyping, labeling, rejection, and loss of status occur and take the form of public or self-stigma, and label avoidance.

### Section 1.3 Review Questions

1. How does social cognition help us to understand why stigmatization occurs?
2. Define stigma and describe its three forms. What is courtesy stigma?
3. What are the effects of stigma on the afflicted?
4. Is stigmatization prevalent in the mental health community? If so, what can be done about it?
5. How can we reduce stigmatization?

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## 1.4. The History of Mental Illness

### Section Learning Objectives

- Describe prehistoric and ancient beliefs about mental illness.
- Describe Greco-Roman thought on mental illness.
- Describe thoughts on mental illness during the Middle Ages.
- Describe thoughts on mental illness during the Renaissance.
- Describe thoughts on mental illness during the 18th and 19th centuries.
- Describe thoughts on mental illness during the 20th and 21st centuries.
- Describe the status of mental illness today.
- Outline the use of psychoactive drugs throughout time and their impact.
- Clarify the importance of managed health care for the treatment of mental illness.
- Define and clarify the importance of multicultural psychology.
- State the issue surrounding prescription rights for psychologists.
- Explain the importance of prevention science.

As we have seen so far, what is considered abnormal behavior is often dictated by the culture/society a person lives in, and unfortunately, the past has not treated the afflicted very well. In this section, we will examine how past societies viewed and dealt with mental illness.

#### 1.4.1. Prehistoric and Ancient Beliefs

Prehistoric cultures often held a supernatural view of abnormal behavior and saw it as the work of evil spirits, demons, gods, or witches who took control of the person. This form of demonic possession often occurred when the person engaged in behavior contrary to the religious teachings of the time. Treatment by cave dwellers included a technique called **trephination**, in which a stone instrument known as a *trephine* was used to remove part of the skull, creating an opening. Through it, the evil spirits could escape, thereby ending the person's mental affliction and returning them to normal behavior. Early Greek, Hebrew, Egyptian, and Chinese cultures used a treatment method called **exorcism** in which evil spirits were cast out through prayer, magic, flogging, starvation, having the person ingest horrible tasting drinks, or noisemaking.

#### 1.4.2. Greco-Roman Thought

Rejecting the idea of demonic possession, Greek physician Hippocrates (460-377 B.C.) said that mental disorders were akin to physical ailments and had natural causes. Specifically, they arose from **brain pathology**, or head trauma/brain dysfunction or disease, and were also affected by heredity. Hippocrates classified mental disorders into three main categories - melancholia, mania, and phrenitis (brain fever) - and gave detailed clinical descriptions of each. He also described four main fluids or **humors** that directed normal brain functioning and personality - **blood** which arose in the heart, **black bile** arising in the spleen, **yellow bile or choler** from the liver, and **phlegm** from the brain. Mental disorders occurred when the humors were in a state of imbalance such as an excess of yellow bile causing frenzy and too much black bile causing melancholia or depression. Hippocrates believed mental illnesses could be treated as any other disorder and focused on the underlying pathology.

Also noteworthy was the Greek philosopher Plato (429-347 B.C.), who said that the mentally ill were not responsible for their actions and should not be punished. It was the responsibility of the community and their families to care for them. The Greek physician Galen (A.D. 129-199) said mental disorders had either physical or psychological causes, including fear, shock, alcoholism, head injuries, adolescence, and changes in menstruation.

In Rome, physician Asclepiades (124-40 BC) and philosopher Cicero (106-43 BC) rejected Hippocrates' idea of the four humors and instead stated that melancholy arises from grief, fear, and rage; not excess black bile. Roman physicians treated mental disorders with massage or warm baths, the hope being that their patients would be as comfortable as they could be. They practiced the concept of **contrariis contrarius**, meaning **opposite by opposite**, and introduced contrasting stimuli to bring about balance in the physical and mental domains. An example would be consuming a cold drink while in a warm bath.

### 1.4.3. The Middle Ages - 500 AD to 1500 AD

The progress made during the time of the Greeks and Romans was quickly reversed during the Middle Ages with the increase in power of the Church and the fall of the Roman Empire. Mental illness was yet again explained as possession by the Devil and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of demonic influence. In extreme cases, the afflicted were exposed to confinement, beatings, and even execution. Scientific and medical explanations, such as those proposed by Hippocrates, were discarded.

Group hysteria, or **mass madness**, was also seen when large numbers of people displayed similar symptoms and false beliefs. This included the belief that one was possessed by wolves or other animals and imitated their behavior, called **lycanthropy**, and a mania in which large numbers of people had an uncontrollable desire to dance and jump, called **tarantism**. The latter was believed to have been caused by the bite of the wolf spider, now called the tarantula, and spread quickly from Italy to Germany and other parts of Europe where it was called **Saint Vitus's dance**.

Perhaps the return to supernatural explanations during the Middle Ages makes sense given events of the time. The black death (bubonic plague) killed up to a third, or according to other estimates almost half, of the population. Famine, war, social oppression, and pestilence were also factors. The constant presence of death led to an epidemic of depression and fear. Near the end of the Middle Ages, mystical explanations for mental illness began to lose favor, and government officials regained some of their lost power over nonreligious activities. Science and medicine were again called upon to explain psychopathology.

### 1.4.4. The Renaissance - 14th to 16th centuries

The most noteworthy development in the realm of philosophy during the Renaissance was the rise of **humanism**, or the worldview that emphasizes human welfare and the uniqueness of the individual. This perspective helped continue the decline of supernatural views of mental illness. In the mid to late 1500s, German physician Johann Weyer (1515-1588) published his book, *On the Deceits of the Demons*, that rebutted the Church's witch-hunting handbook, the *Malleus Maleficarum*, and argued that many accused of being witches and subsequently imprisoned, tortured, and/or burned at the stake, were mentally disturbed and not possessed by demons or the Devil himself. He believed that like the body, the mind was susceptible to illness. Not surprisingly, the book was vehemently protested and banned by the Church. It should be noted that these types of acts occurred not only in Europe, but also in the United States. The most famous example, the Salem Witch Trials of 1692, resulted in more than 200 people accused of practicing witchcraft and 20 deaths.

The number of **asylums**, or places of refuge for the mentally ill where they could receive care, began to rise during the 16th century as the government realized there were far too many people afflicted with mental illness to be left in private homes. Hospitals and monasteries were converted into asylums. Though the intent was benign in the beginning, as the facilities overcrowded, the patients came to be treated more like animals than people. In 1547, the Bethlem Hospital opened in London with the sole purpose of confining those with mental disorders. Patients were chained up, placed on public display, and often heard crying out in pain. The asylum became a tourist attraction, with sightseers paying a penny to view the more violent patients, and soon was called "Bedlam" by local people; a term that today means "a state of uproar and confusion" (<https://www.merriam-webster.com/dictionary/bedlam>).

### 1.4.5. Reform Movement - 18th to 19th centuries

The rise of the **moral treatment movement** occurred in Europe in the late 18th century and then in the United States in the early 19th century. The earliest proponent was Francis Pinel (1745-1826), the superintendent of la Bicetre, a hospital for mentally ill men in Paris. Pinel stressed respectful treatment and moral guidance for the mentally ill while considering their individual, social, and occupational needs. Arguing that the mentally ill were sick people, Pinel ordered that chains be removed, outside exercise be allowed, sunny and well-ventilated rooms replace dungeons, and patients be extended kindness and support. This approach led to considerable improvement for many of the patients, so much so, that several were released.

Following Pinel's lead, William Tuke (1732-1822), a Quaker tea merchant, established a pleasant rural estate called the York Retreat. The Quakers believed that all people should be accepted for who they are and treated kindly. At the retreat, patients could work, rest, talk out their problems, and pray (Raad & Makari, 2010). The work of Tuke and others led to the passage of the Country Asylums Act of 1845, which required that every county provide asylum to the mentally ill. This sentiment extended to English colonies such as Canada, India, Australia, and the West Indies as word of the maltreatment of patients at a facility in Kingston, Jamaica spread, leading to an audit of colonial facilities and their policies.

Reform in the United States started with the figure largely considered to be the father of American psychiatry, Benjamin Rush (1745-1813). Rush advocated for the humane treatment of the mentally ill, showing them respect, and even giving them small gifts from time to time. Despite this, his practice included treatments such as bloodletting and purgatives, the invention of the "tranquilizing chair," and reliance on astrology, showing that even he could not escape from the beliefs of the time.

Due to the rise of the moral treatment movement in both Europe and the United States, asylums became habitable places where those afflicted with mental illness could recover. Regrettably, its success was responsible for its decline. The number of mental hospitals greatly increased, leading to staffing shortages and a lack of funds to support them. Though treating patients humanely was a noble endeavor, it did not work for some patients and other treatments were needed, though they had not been developed yet. Staff recognized that the approach worked best when the facility had 200 or fewer patients, but waves of immigrants arriving in the U.S. after the Civil War overwhelmed the facilities, and patient counts soared to 1,000 or more. Prejudice against the new arrivals led to discriminatory practices in which immigrants were not afforded the same moral treatments as native citizens, even when the resources were available to treat them.

The moral treatment movement also fell due to the rise of the **mental hygiene movement**, which focused on the physical well-being of patients. Its leading proponent in the United States was Dorothea Dix (1802-1887), a New Englander who observed the deplorable conditions suffered by the mentally ill while teaching Sunday school to female prisoners. Over the next 40 years, from 1841 to 1881, she motivated people and state legislators to do something about this injustice and raised millions of dollars to build over 30 more appropriate mental hospitals and improve others. Her efforts even extended beyond the U.S. to Canada and Scotland.

Finally, in 1908 Clifford Beers (1876-1943) published his book, *A Mind that Found Itself*, in which he described his struggle with bipolar disorder and the "cruel and inhumane treatment people with mental illnesses received. He witnessed and experienced horrific abuse at the hands of his caretakers. At one

point during his institutionalization, he was placed in a straitjacket for 21 consecutive nights” (<https://www.mhanational.org/our-history>). His story aroused sympathy from the public and led him to found the National Committee for Mental Hygiene, known today as Mental Health America, which provides education about mental illness and the need to treat these people with dignity. Today, MHA has over 200 affiliates in 41 states and employs 6,500 affiliate staff and over 10,000 volunteers.

“In the early 1950s, Mental Health America issued a call to asylums across the country for their discarded chains and shackles. On April 13, 1953, at the McShane Bell Foundry in Baltimore, Md., Mental Health America melted down these inhumane bindings and recast them into a sign of hope: the Mental Health Bell.

Now the symbol of Mental Health America, the 300-pound Bell serves as a powerful reminder that the invisible chains of misunderstanding and discrimination continue to bind people with mental illnesses. Today, the Mental Health Bell rings out hope for improving mental health and achieving victory over mental illnesses.”

For more information on MHA, please visit: <https://www.mhanational.org/>

#### 1.4.6. 20th - 21st Centuries

The decline of the moral treatment approach in the late 19th century led to the rise of two competing perspectives – the biological or somatogenic perspective and the psychological or psychogenic perspective.

**1.4.6.1. Biological or Somatogenic Perspective.** Recall that Greek physicians Hippocrates and Galen said that mental disorders were akin to physical disorders and had natural causes. Though the idea fell into oblivion for several centuries, it re-emerged in the late 19th century for two reasons. First, German psychiatrist Emil Kraepelin (1856-1926) discovered that symptoms occurred regularly in clusters, which he called **syndromes**. These syndromes represented a unique mental disorder with a distinct cause, course, and prognosis. In 1883 he published his textbook, *Compendium der Psychiatrie* (Textbook of Psychiatry), and described a system for classifying mental disorders that became the basis of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)* that is currently in its 5th edition Text Revision (published in 2022).

Secondly, in 1825, the behavioral and cognitive symptoms of advanced syphilis were identified to include a belief that everyone is plotting against you or that you are God (a delusion of grandeur), and were termed *general paresis* by French physician A.L.J. Bayle. In 1897, Viennese psychiatrist Richard von Krafft-Ebbing injected patients suffering from general paresis with matter from syphilis spores and noted that none of the patients developed symptoms of syphilis, indicating they must have been previously exposed and were now immune. This led to the conclusion that syphilis was the cause of the general paresis. In 1906, August von Wassermann developed a blood test for syphilis, and in 1917 a cure was found. Julius von Wagner-Jauregg noticed that patients with general paresis who contracted malaria recovered from their symptoms. To test this hypothesis, he injected nine patients with blood from a soldier afflicted with malaria. Three of the patients fully recovered while three others showed great improvement in their paretic symptoms. The high fever caused by malaria burned out the syphilis bacteria. Hospitals in the United States began incorporating this new cure for paresis into their treatment approach by 1925.

Also noteworthy was the work of American psychiatrist John P. Grey. Appointed as superintendent of the Utica State Hospital in New York, Grey asserted that insanity always had a physical cause. As such, the mentally ill should be seen as physically ill and treated with rest, proper room temperature and ventilation, and a nutritive diet.

The 1930s also saw the use of electric shock as a treatment method, which was stumbled upon accidentally by Benjamin Franklin while experimenting with electricity in the early 18th century. He noticed that after suffering a severe shock his memories had changed, and in published work, he suggested physicians study electric shock as a treatment for melancholia.

**1.4.6.2. Psychological or Psychogenic Perspective.** The **psychological or psychogenic perspective** states that emotional or psychological factors are the cause of mental disorders and represented a challenge to the biological perspective. This perspective had a long history but did not gain favor until the work of Viennese physician Franz Anton Mesmer (1734-1815). **Influenced heavily by Newton's theory of gravity, he believed that the planets also affected the human body through the force of animal magnetism and that all people had a universal magnetic fluid that determined how healthy they were.** He demonstrated the usefulness of his approach when he cured Franzl Oesterline, a 27-year-old woman suffering from what he described as a convulsive malady. Mesmer used a magnet to disrupt the gravitational tides that were affecting his patient and produced a sensation of the magnetic fluid draining from her body. This procedure removed the illness from her body and provided a near-instantaneous recovery. In reality, the patient was placed in a trancelike state which made her highly suggestible. With other patients, Mesmer would have them sit in a darkened room filled with soothing music, into which he would enter dressed in a colorful robe and pass from person to person touching the afflicted area of their body with his hand or a rod/wand. He successfully cured deafness, paralysis, loss of bodily feeling, convulsions, menstrual difficulties, and blindness.

His approach gained him celebrity status as he demonstrated it at the courts of English nobility. However, the medical community was hardly impressed. A royal commission was formed to investigate his technique but could not find any proof for his theory of animal magnetism. Though he was able to cure patients when they touched his "magnetized" tree, the result was the same when "non-magnetized" trees were touched. As such, Mesmer was deemed a charlatan and forced to leave Paris. His technique was called **mesmerism**, better known today as **hypnosis**.

The psychological perspective gained popularity after two physicians practicing in the city of Nancy in France discovered that they could induce the symptoms of hysteria in perfectly healthy patients through hypnosis and then remove the symptoms in the same way. The work of Hippolyte-Marie Bernheim (1840-1919) and Ambroise-Auguste Liebault (1823-1904) came to be part of what was called the Nancy School and showed that hysteria was nothing more than a form of self-hypnosis. In Paris, this view was challenged by Jean Charcot (1825-1893), who stated that hysteria was caused by degenerative brain changes, reflecting the biological perspective. He was proven wrong and eventually turned to their way of thinking.

The use of hypnosis to treat hysteria was also carried out by fellow Frenchman Pierre Janet (1859-1947), and student of Charcot, who believed that hysteria had psychological, not biological causes. Namely, these included unconscious forces, fixed ideas, and memory impairments. In Vienna, Josef Breuer (1842-1925) induced hypnosis and had patients speak freely about past events that upset them. Upon waking, he discovered that patients sometimes were free of their symptoms of hysteria. Success was even greater when patients not only recalled forgotten memories but also relived them

emotionally. He called this the **cathartic method**, and our use of the word **catharsis** today indicates a purging or release, in this case, of pent-up emotion.

By the end of the 19th century, it had become evident that mental disorders were caused by a combination of biological and psychological factors, and the investigation of how they develop began. Sigmund Freud's development of psychoanalysis followed on the heels of the work of Bruner, and others who came before him.

### 1.4.7. Current Views/Trends

**1.4.7.1. Mental illness today.** An article published by the Harvard Medical School in March 2014 called "The Prevalence and Treatment of Mental Illness Today" presented the results of the National Comorbidity Study Replication of 2001-2003, which included a sample of more than 9,000 adults. The results showed that nearly 46% of the participants had a psychiatric disorder at some time in their lives. The most commonly reported disorders were:

- Major depression - 17%
- Alcohol abuse - 13%
- Social anxiety disorder - 12%
- Conduct disorder - 9.5%

Also of interest was that women were more likely to have had anxiety and mood disorders while men showed higher rates of impulse control disorders. Comorbid anxiety and mood disorders were common, and 28% reported having more than one co-occurring disorder (Kessler, Berglund, et al., 2005; Kessler, Chiu, et al., 2005; Kessler, Demler, et al., 2005).

About 80% of the sample reported seeking treatment for their disorder, but with as much as a 10-year gap after symptoms first appeared. Women were more likely than men to seek help while whites were more likely than African and Hispanic Americans (Wang, Berglund, et al., 2005; Wang, Lane, et al., 2005). Care was sought primarily from family doctors, nurses, and other general practitioners (23%), followed by social workers and psychologists (16%), psychiatrists (12%), counselors or spiritual advisers (8%), and complementary and alternative medicine providers (CAMs; 7%).

In terms of the quality of the care, the article states:

Most of this treatment was inadequate, at least by the standards applied in the survey. The researchers defined minimum adequacy as a suitable medication at a suitable dose for two months, along with at least four visits to a physician; or else eight visits to any licensed mental health professional. By that definition, only 33% of people with a psychiatric disorder were treated adequately, and only 13% of those who saw general medical practitioners.

In comparison to the original study conducted from 1991-1992, the use of mental health services has increased over 50% during this decade. This may be attributed to treatment becoming more widespread and increased attempts to educate the public about mental illness. Stigma, discussed in Section 1.3, has reduced over time, diagnosis is more effective, community outreach programs have increased, and most importantly, general practitioners have been more willing to prescribe psychoactive medications which themselves are more readily available now. The article concludes, "Survey researchers also suggest that

we need more outreach and voluntary screening, more education about mental illness for the public and physicians, and more effort to treat substance abuse and impulse control disorders.” We will explore several of these issues in the remainder of this section, including the use of psychiatric drugs and deinstitutionalization, managed health care, private psychotherapy, positive psychology and prevention science, multicultural psychology, and prescription rights for psychologists.

**1.4.7.2. Use of psychiatric drugs and deinstitutionalization.** Beginning in the 1950s, psychiatric or psychotropic drugs were used for the treatment of mental illness and made an immediate impact. Though drugs alone cannot cure mental illness, they can improve symptoms and increase the effectiveness of treatments such as psychotherapy. Classes of psychiatric drugs include anti-depressants used to treat depression and anxiety, mood-stabilizing medications to treat bipolar disorder, anti-psychotic drugs to treat schizophrenia, and anti-anxiety drugs to treat generalized anxiety disorder or panic disorder

Frank (2006) found that by 1996, psychotropic drugs were used in 77% of mental health cases and spending on these drugs grew from \$2.8 billion in 1987 to about \$18 billion in 2001 (Coffey et al., 2000; Mark et al., 2005), representing over a sixfold increase. The largest classes of psychotropic drugs are anti-psychotics and anti-depressants, followed closely by anti-anxiety medications. Frank, Conti, and Goldman (2005) point out, “The expansion of insurance coverage for prescription drugs, the introduction and diffusion of managed behavioral health care techniques, and the conduct of the pharmaceutical industry in promoting their products all have influenced how psychotropic drugs are used and how much is spent on them.” Is it possible then that we are overprescribing these medications? Davey (2014) provides ten reasons why this may be so, including leading suffers from believing that recovery is in their hands but instead in the hands of their doctors; increased risk of relapse; drug companies causing the “medicalization of perfectly normal emotional processes, such as bereavement” to ensure their survival; side effects; and a failure to change the way the person thinks or the socioeconomic environments that may be the cause of the disorder. For more on this article, please see: <https://www.psychologytoday.com/blog/why-we-worry/201401/overprescribing-drugs-treat-mental-health-problems>. Smith (2012) echoed similar sentiments in an article on inappropriate prescribing. He cites the approval of Prozac by the Food and Drug Administration (FDA) in 1987 as when the issue began and the overmedication/overdiagnosis of children with ADHD as a more recent example.

A result of the use of psychiatric drugs was deinstitutionalization, or the release of patients from mental health facilities. This shifted resources from inpatient to outpatient care and placed the spotlight back on the biological or somatogenic perspective. When people with severe mental illness do need inpatient care, it is typically in the form of short-term hospitalization.

**1.4.7.3. Managed health care.** Managed health care is a term used to describe a type of health insurance in which the insurance company determines the cost of services, possible providers, and the number of visits a subscriber can have within a year. This is regulated through contracts with providers and medical facilities. The plans pay the providers directly, so subscribers do not have to pay out-of-pocket or complete claim forms, though most require co-pays paid directly to the provider at the time of service. Exactly how much the plan costs depends on how flexible the subscriber wants it to be; the more flexibility, the higher the cost. Managed health care takes three forms:

- **Health Maintenance Organizations (HMO)** – Typically only pay for care within the network. The subscriber chooses a primary care physician (PCP) who coordinates most of their care. The PCP refers the subscriber to specialists or other health care providers as is necessary. This is the most

restrictive option.

- **Preferred Provider Organizations (PPO)** – Usually pay more if the subscriber obtains care within the network, but if care outside the network is sought, they cover part of the cost.
- **Point of Service (POS)** – These plans provide the most flexibility and allow the subscriber to choose between an HMO or a PPO each time care is needed.

Regarding the treatment needed for mental illness, managed care programs regulate the pre-approval of treatment via referrals from the PCP, determine which mental health providers can be seen, and oversee which conditions can be treated and what type of treatment can be delivered. This system was developed in the 1980s to combat the rising cost of mental health care and took responsibility away from single practitioners or small groups who could charge what they felt was appropriate. The actual impact of managed care on mental health services is still questionable at best.

**1.4.7.4. Multicultural psychology.** As our society becomes increasingly diverse, medical practitioners and psychologists alike must take into account the patient's gender, age, race, ethnicity, socioeconomic (SES) status, and culture and how these factors shape the individual's thoughts, feelings, and behaviors. Additionally, we need to understand how the various groups, whether defined by race, culture, or gender, differ from one another. This approach is called **multicultural psychology**.

In August 2002, the American Psychological Association's (APA) Council of Representatives put forth six guidelines based on the understanding that "race and ethnicity can impact psychological practice and interventions at all levels" and the need for respect and inclusiveness. They further state, "psychologists are in a position to provide leadership as agents of prosocial change, advocacy, and social justice, thereby promoting societal understanding, affirmation, and appreciation of multiculturalism against the damaging effects of individual, institutional, and societal racism, prejudice, and all forms of oppression based on stereotyping and discrimination." The guidelines from the 2002 document are as follows:

- **Guideline #1:** Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.
- **Guideline #2:** Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.
- **Guideline #3:** As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.
- **Guideline #4:** Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.
- **Guideline #5:** Psychologists strive to apply culturally-appropriate skills in clinical and other applied psychological practices.
- **Guideline #6:** Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices."

Source: <https://apa.org/pi/oema/resources/policy/multicultural-guidelines.aspx>

This type of sensitivity training is vital because bias based on ethnicity, race, and culture has been found in the diagnosis and treatment of autism (Harrison et al., 2017; Burkett, 2015), borderline

personality disorder (Jani et al., 2016), and schizophrenia (Neighbors et al., 2003; Minsky et al., 2003). Despite these findings, Schwartz and Blankenship (2014) state, “It should also be noted that although clear evidence supports a longstanding trend in differential diagnoses according to consumer race, this trend does not imply that one race (*e.g.*, African Americans) actually demonstrate more severe symptoms or higher prevalence rates of psychosis compared with other races (*e.g.*, Euro-Americans). Because clinicians are the diagnosticians and misinterpretation, bias or other factors may play a role in this trend caution should be used when making inferences about actual rates of psychosis among ethnic minority persons.” Additionally, white middle-class help seekers were offered appointments with psychotherapists almost three times as often as their black working-class counterparts. Women were offered an appointment time in their preferred time range more than men were, though average appointment offer rates were similar between genders (Kugelmass, 2016). These findings collectively show that though we are becoming more culturally sensitive, we have a lot more work to do.

**1.4.7.5. Prescription rights for psychologists.** To reduce inappropriate prescribing as described in 1.4.7.2, it has been proposed to allow appropriately trained psychologists the right to prescribe. Psychologists are more likely to utilize both therapy and medication, and so can make the best choice for their patient. The right has already been granted in New Mexico, Louisiana, Guam, the military, the Indian Health Services, and the U.S. Public Health Services. Measures in other states “have been opposed by the American Medical Association and American Psychiatric Association over concerns that inadequate training of psychologists could jeopardize patient safety. Supporters of prescriptive authority for psychologists are quick to point out that there is no evidence to support these concerns” (Smith, 2012).

**1.4.7.6. Prevention science.** As a society, we used to wait for a mental or physical health issue to emerge, then scramble to treat it. More recently, medicine and science has taken a **prevention** stance, **identifying the factors that cause specific mental health issues and implementing interventions to stop them from happening, or at least minimize their deleterious effects**. Our focus has shifted from individuals to the population. Mental health promotion programs have been instituted with success in schools (Shoshani & Steinmetz, 2014; Weare & Nind, 2011; Berkowitz & Beer, 2007), in the workplace (Czabała, Charzyńska, & Mroziak, B., 2011), with undergraduate and graduate students (Conley et al., 2017; Bettis et al., 2016), in relation to bullying (Bradshaw, 2015), and with the elderly (Forsman et al., 2011). Many researchers believe it is the ideal time to move from knowledge to action and to expand public mental health initiatives (Wahlbeck, 2015). The growth of positive psychology in the late 1990s has further propelled this movement forward. For more on positive psychology, please see Section 1.1.1.

## Key Takeaways

You should have learned the following in this section:

- Some of the earliest views of mental illness saw it as the work of evil spirits, demons, gods, or witches who took control of the person, and in the Middle Ages it was seen as possession by the Devil and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of demonic influence.
- During the Renaissance, humanism was on the rise which emphasized human welfare and the uniqueness of the individual and led to an increase in the number of asylums as places of refuge

for the mentally ill.

- The 18th to 19th centuries saw the rise of the moral treatment movement followed by the mental hygiene movement.
- The psychological or psychogenic perspective states that emotional or psychological factors are the cause of mental disorders and represented a challenge to the biological perspective which said that mental disorders were akin to physical disorders and had natural causes.
- Psychiatric or psychotropic drugs used to treat mental illness became popular beginning in the 1950s and led to deinstitutionalization or a shift from inpatient to outpatient care.

#### Section 1.4 Review Questions

1. How has mental illness been viewed across time?
2. Contrast the moral treatment and mental hygiene movements.
3. Contrast the biological or somatogenic perspective with that of the psychological or psychogenic perspective.
4. Discuss contemporary trends in relation to the use of drugs to treat mental illness, deinstitutionalization, managed health care, multicultural psychology, prescription rights for psychologists, and prevention science.

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## 1.5. Research Methods in Psychopathology

#### Section Learning Objectives

- Define the scientific method.
- Outline and describe the steps of the scientific method, defining all key terms.
- Identify and clarify the importance of the three cardinal features of science.
- List the five main research methods used in psychology.
- Describe observational research, listing its advantages and disadvantages.
- Describe case study research, listing its advantages and disadvantages.
- Describe survey research, listing its advantages and disadvantages.
- Describe correlational research, listing its advantages and disadvantages.
- Describe experimental research, listing its advantages and disadvantages.
- State the utility and need for multimethod research.

#### 1.5.1. The Scientific Method

**Psychology** is the “scientific study of behavior and mental processes.” We will spend quite a lot of time on the behavior and mental processes part throughout this book and in relation to mental disorders.

Still, before we proceed, it is prudent to further elaborate on what makes psychology scientific. It is safe to say that most people outside of our discipline or a sister science would be surprised to learn that psychology utilizes the scientific method at all. That may be even truer of clinical psychology, especially in light of the plethora of self-help books found at any bookstore. But yes, the treatment methods used by mental health professionals are based on empirical research and the scientific method.

As a starting point, we should expand on what the scientific method is.

The **scientific method** is a systematic method for gathering knowledge about the world around us.

The keyword here is *systematic*, meaning there is a set way to use it. What is that way? Well, depending on what source you look at, it can include a varying number of steps. I like to use the following:

Table 1.1: The Steps of the Scientific Method

Step Name		Description
0	Ask questions and be willing to wonder.	To study the world around us, you have to wonder about it. This inquisitive nature is the hallmark of <b>critical thinking</b> —our ability to assess claims made by others and make objective judgments that are independent of emotion and anecdote and based on hard evidence —and a requirement to be a scientist.
1	Generate a research question or identify a problem to investigate.	Through our wonderment about the world around us and why events occur as they do, we begin to ask questions that require further investigation to arrive at an answer. This investigation usually starts with a <b>literature review</b> , or when we conduct a literature search through our university library or a search engine such as Google Scholar to see what questions have been investigated already and what answers have been found, so that we can identify <b>gaps</b> or holes in this body of work.
2	Attempt to explain the phenomena we wish to study.	We now attempt to formulate an explanation of why the event occurs as it does. This systematic explanation of a phenomenon is a <b>theory</b> and our specific, testable prediction is the <b>hypothesis</b> . We will know if our theory is correct because we have formulated a hypothesis that we can now test.
3	Test the hypothesis.	It goes without saying that if we cannot test our hypothesis, then we cannot show whether our prediction is correct or not. Our plan of action of how we will go about testing the hypothesis is called our <b>research design</b> . In the planning stage, we will select the appropriate research method to answer our question/test our hypothesis.

- |   |   |  |
|---|---|--|
| 4 | Interpret the results.  | <p>With our research study done, we now examine the data to see if the pattern we predicted exists. We need to see if a cause and effect statement can be made, assuming our method allows for this inference. More on this in Section 2.3. For now, it is essential to know that statistics have two forms. First, there are <b>descriptive statistics</b> which provide a means of summarizing or describing data and presenting the data in a usable form. You likely have heard of mean or average, median, and mode. Along with standard deviation and variance, these are ways to describe our data. Second, there are <b>inferential statistics</b> that allow for the analysis of two or more sets of numerical data to determine the <b>statistical significance</b> of the results. Significance is an indication of how confident we are that our results are due to our manipulation or design and not chance.</p> |
| 5 | Draw conclusions carefully.                                   | <p>We need to interpret our results accurately and not overstate our findings. To do this, we need to be aware of our biases and avoid emotional reasoning so that they do not cloud our judgment. How so? In our effort to stop a child from engaging in self-injurious behavior that could cause substantial harm or even death, we might overstate the success of our treatment method.</p>   |
| 6 | Communicate our findings to the broader scientific community. | <p>Once we have decided on whether our hypothesis was correct or not, we need to share this information with others so that they might comment critically on our methodology, statistical analyses, and conclusions. Sharing also allows for <b>replication</b> or repeating the study to confirm its results. Communication occurs via scientific journals, conferences, or newsletters released by many of the organizations mentioned in Module 1.6.</p>  |

Science has at its root three *cardinal features* that we will see play out time and time again throughout this book. They are:

1. *Observation* – To know about the world around us, we have to be able to see it firsthand. When a mental disorder afflicts an individual, we can see it through their overt behavior. An individual with depression may withdraw from activities he/she enjoys, those with social anxiety disorder will avoid social situations, people with schizophrenia may express concern over being watched by the government, and individuals with dependent personality disorder may leave major decisions to trusted companions. In these examples and numerous others, the behaviors that lead us to a diagnosis of a specific disorder can easily be observed by the clinician, the patient, and/or family and friends.
2. *Experimentation* – To be able to make *causal* or cause and effect statements, we must isolate variables. We must manipulate one variable and see the effect of doing so on another variable. Let's say we want to know if a new treatment for bipolar disorder is as effective as existing treatments, or more importantly, better. We could design a study with three groups of bipolar patients. One group would receive no treatment and serve as a control group. A second group would receive an existing and proven treatment and would also be considered a control group. Finally, the third group would receive the new treatment and be the experimental group. What we are manipulating is what treatment the groups get – no treatment, the older treatment, and the newer treatment. The first two groups serve as controls since we already know what to expect from their results. There should be no change in bipolar disorder symptoms in the no-treatment group, a general reduction in symptoms for the older treatment group, and the same or better performance for the newer treatment group. As long as patients in the newer treatment group do not perform worse than their older treatment counterparts, we can say the new drug is a success.

You might wonder why we would get excited about the performance of the new drug being the same as the old drug. Does it really offer any added benefit? In terms of a reduction of symptoms, maybe not, but it could cost less money than the older drug and that would be of value to patients.

3. **Measurement** – How do we know that the new drug has worked? Simply, we can measure the person's bipolar disorder symptoms before any treatment was implemented, and then again once the treatment has run its course. This pre-post test design is typical in drug studies.

### 1.5.2. Research Methods

Step 3 called on the scientist to test his or her hypothesis. Psychology as a discipline uses five main research designs. They are:

**1.5.2.1. Naturalistic and laboratory observation.** In terms of **naturalistic observation**, the scientist studies human or animal behavior in its natural environment, which could include the home, school, or a forest. The researcher counts, measures, and rates behavior in a systematic way and, at times, uses multiple judges to ensure accuracy in how the behavior is being measured. The advantage of this method is that you see behavior as it happens, and the experimenter does not taint the data. The disadvantage is that it could take a long time for the behavior to occur, and if the researcher is detected, then this may influence the behavior of those being observed.

**Laboratory observation** involves observing people or animals in a laboratory setting. The researcher might want to know more about parent-child interactions, and so, brings a mother and her child into the lab to engage in preplanned tasks such as playing with toys, eating a meal, or the mother leaving the room for a short time. The advantage of this method over the naturalistic method is that the experimenter can use sophisticated equipment to record the session and examine it later. The problem is that since the subjects know the experimenter is watching them, their behavior could become artificial. Clinical observation is a commonly employed research method to study psychopathology; we will talk about it more throughout this book.

**1.5.2.2. Case studies.** Psychology can also utilize a detailed description of one person or a small group based on careful observation. This was the approach the founder of psychoanalysis, Sigmund Freud, took to develop his theories. The advantage of this method is that you arrive at a detailed description of the investigated behavior, but the disadvantage is that the findings may be unrepresentative of the larger population, and thus, lacking **generalizability**. Again, bear in mind that you are studying one person or a tiny group. Can you possibly make conclusions about all people from just one person, or even five or ten? The other issue is that the case study is subject to researcher bias in terms of what is included in the final narrative and what is left out. Despite these limitations, case studies can lead us to novel ideas about the cause of abnormal behavior and help us to study unusual conditions that occur too infrequently to analyze with large sample sizes and in a systematic way.

**1.5.2.3. Surveys/Self-Report data.** This is a questionnaire consisting of at least one scale with some questions used to assess a psychological construct of interest such as parenting style, depression, locus of control, or sensation-seeking behavior. It may be administered by paper and pencil or computer. Surveys allow for the collection of large amounts of data quickly, but the actual survey could be tedious for the participant and **social desirability**, when a participant answers questions dishonestly so that they are seen in a more favorable light, could be an issue. For instance, if you are asking high school students about their sexual activity, they may not give genuine answers for fear that

their parents will find out. You could alternatively gather this information via an interview in a structured or unstructured fashion.

**1.5.2.4. Correlational research.** This research method examines the relationship between two variables or two groups of variables. A numerical measure of the strength of this relationship is derived, called the *correlation coefficient*. It can range from -1.00, a perfect inverse relationship in which one variable goes up as the other goes down, to 0 indicating no relationship at all, to +1.00 or a perfect relationship in which as one variable goes up or down so does the other. In terms of a negative correlation, we might say that as a parent becomes more rigid, controlling, and cold, the attachment of the child to parent goes down. In contrast, as a parent becomes warmer, more loving, and provides structure, the child becomes more attached. The advantage of correlational research is that you can correlate anything. The disadvantage is that you can correlate anything, including variables that do not have any relationship with one another. Yes, this is both an advantage and a disadvantage. For instance, we might correlate instances of making peanut butter and jelly sandwiches with someone we are attracted to sitting near us at lunch. Are the two related? Not likely, unless you make a really good PB&J, but then the person is probably only interested in you for food and not companionship. The main issue here is that correlation *does not* allow you to make a causal statement.

A special form of correlational research is the **epidemiological study** in which the prevalence and incidence of a disorder in a specific population are measured (See Section 1.2 for definitions).

**1.5.2.5. Experiments.** This is a controlled test of a hypothesis in which a researcher manipulates one variable and measures its effect on another variable. The **manipulated variable** is called the **independent variable (IV)**, and the one that is measured is called the **dependent variable (DV)**. In the example under Experimentation in Section 1.5.1, the treatment for bipolar disorder was the IV, while the actual intensity or number of symptoms serve as the DV. A **common feature of experiments** is a **control group** that **does not receive the treatment or is not manipulated** and an **experimental group** that **does receive the treatment or manipulation**. If the experiment includes **random assignment**, participants have an equal chance of being placed in the control or experimental group. The control group allows the researcher (or teacher) to make a *comparison* to the experimental group and make a causal statement possible, and stronger. In our experiment, the new treatment should show a marked reduction in the intensity of bipolar symptoms compared to the group receiving no treatment, and perform either at the same level as, or better than, the older treatment. This would be the initial hypothesis made before starting the experiment.

In a drug study, to ensure the participants' expectations do not affect the final results by giving the researcher what he/she is looking for (in our example, symptoms improve whether the participant is receiving treatment or not), we might use what is called a **placebo**, or a sugar pill made to look exactly like the pill given to the experimental group. This way, participants all are given something, but cannot figure out what exactly it is. You might say this keeps them honest and allows the results to speak for themselves.

Finally, the study of mental illness does not always afford us a large sample of participants to study, so we have to focus on one individual using a **single-subject experimental design**. This differs from a case study in the sheer number of strategies available to reduce potential **confounding variables**, or variables not originally part of the research design but contribute to the results in a meaningful way. One type of single-subject experimental design is the **reversal** or **ABAB design**. Kuttler, Myles, and Carson (1998) used social stories to reduce tantrum behavior in two social environments in a 12-year

old student diagnosed with autism, Fragile-X syndrome, and intermittent explosive disorder. Using an ABAB design, they found that precursors to tantrum behavior decreased when the social stories were available (B) and increased when the intervention was withdrawn (A). A more recent study (Balakrishnan & Alias, 2017) also established the utility of social stories as a social learning tool for children with autism spectrum disorder (ASD) using an ABAB design. During the baseline phase (A), the four student participants were observed, and data recorded on an observation form. During the treatment phase (B), they listened to the social story and data was recorded in the same manner. Upon completion of the first B, the students returned to A, which was followed one more time by B and the reading of the social story. Once the second treatment phase ended, the participation was monitored again to obtain the outcome. All students showed improvement during the treatment phases in terms of the number of positive peer interactions, but the number of interactions reduced in the absence of social stories. From this, the researchers concluded that the social story led to the increase in positive peer interactions of children with ASD.

**1.5.2.6. Multi-method research.** As you have seen above, no single method alone is perfect. All have strengths and limitations. As such, for the psychologist to provide the most precise picture of what is affecting behavior or mental processes, several of these approaches are typically employed at different stages of the research study. This is called **multi-method research**.

## Key Takeaways

You should have learned the following in this section:

- The scientific method is a systematic method for gathering knowledge about the world around us.
- A systematic explanation of a phenomenon is a theory and our specific, testable prediction is the hypothesis.
- Replication is when we repeat the study to confirm its results.
- Psychology's five main research designs are observation, case studies, surveys, correlation, and experimentation.
- No single research method alone is perfect – all have strengths and limitations.

## Section 1.5 Review Questions

1. What is the scientific method and what steps make it up?
2. Differentiate theory and hypothesis.
3. What are the three cardinal features of science and how do they relate to the study of mental disorders?
4. What are the five main research designs used by psychologists? Define each and then state its strengths and limitations.
5. What is the advantage of multi-method research?

## 1.6. Mental Health Professionals, Societies, and Journals



### Section Learning Objectives

- Identify and describe the various types of mental health professionals.
- Clarify what it means to communicate findings.
- Identify professional societies in clinical psychology.
- Identify publications in clinical psychology.

### 1.6.1. Types of Professionals

There are many types of mental health professionals that people may seek out for assistance. They include:

*Table 1.2: Types of Mental Health Professionals*

Name	Degree Required	Function/Training	Can they prescribe medications?
Clinical Psychologist	Ph.D.	Trained to make diagnoses and can provide individual and group therapy	Only in select states
School Psychologist	Masters or Ph.D.	Trained to make diagnoses and can provide individual and group therapy but also works with school staff	No
Counseling Psychologist	Ph.D.		 Only in select states
Clinical Social Worker	M.S.W. or Ph.D.	Trained to make diagnoses and can provide individual and group therapy and is involved in advocacy and case management. Usually in hospital settings.	No
Psychiatrist	M.D.	Has specialized training in the diagnosis and treatment of mental disorders	Yes
Psychiatric Nurse Practitioner	M.S.N.	Has specialized treatment in the care and treatment of psychiatric patients	Yes
Occupational Therapist	B.S.	Trained to assist individuals suffering from physical or psychological handicaps and help them acquire needed resources	No
Pastoral Counselor	Clergy	Trained in pastoral education and can make diagnoses and can provide individual and group therapy	No

Drug Abuse and/or Alcohol Counselor	B.S. or higher	Trained in alcohol and drug abuse and can make diagnoses and can provide individual and group therapy	No
Child/Adolescent Psychiatrist	M.D. or Ph.D.	Specialized training in the diagnosis and treatment of mental illness in children	Yes
Marital and Family Therapist	Masters	Specialized training in marital and family therapy; Can make diagnoses and can provide individual and group therapy	No

For more information on types of mental health professionals, please visit:

<https://www.mhanational.org/types-mental-health-professionals>

### 1.6.2. Professional Societies and Journals

One of the functions of science is to communicate findings. Testing hypotheses, developing sound methodology, accurately analyzing data, and drawing sound conclusions are important, but you must tell others what you have done too. This is accomplished by joining professional societies and submitting articles to peer-reviewed journals. Below are some of the organizations and journals relevant to applied behavior analysis.

#### 1.6.2.1. Professional Societies

- **Society of Clinical Psychology - Division 12 of the American Psychological Association**

- Website - <https://div12.org/>
- Mission Statement - "The mission of the Society of Clinical Psychology is to represent the field of Clinical Psychology through encouragement and support of the integration of clinical psychological science and practice in education, research, application, advocacy and public policy, attending to the importance of diversity."
- Publications - Clinical Psychology: Science and Practice and the newsletter Clinical Psychology: Science and Practice(quarterly)
- Other Information - Members and student affiliates may join one of eight sections such as clinical emergencies and crises, clinical psychology of women, assessment psychology, and clinical geropsychology

- **Society of Clinical Child and Adolescent Psychology - Division 53 of the American Psychological Association**

- Website - <https://www.clinicalchildpsychology.org/>
- Mission Statement - "Our mission is to serve children, adolescents and families with the best possible clinical care based on psychological science. SCCAP strives to integrate scientific and professional aspects of clinical child and adolescent psychology, in that it promotes scientific inquiry, training, and clinical practice related to serving children and their families."

- Publication – Journal of Clinical Child and Adolescent Psychology

- **American Academy of Clinical Psychology**

- Website – <https://www.aacpsy.org/>
- Mission Statement – The American Academy of Clinical Psychology seeks to “recognize and promote advanced competence within Professional Psychology,” “provide a professional community that encourages communication between and among Members and Fellows of the Academy,” “provide opportunities for advanced education in Professional Psychology,” and “expand awareness and availability of AACCP Members and Fellows to the public through promotion and education.”
- Publication – Bulletin of the American Academy of Clinical Psychology (newsletter)

- **The Society for a Science of Clinical Psychology (SSCP)**

- Website – <http://www.sscpweb.org/>
- Mission Statement – “**The Society for a Science of Clinical Psychology (SSCP)** was established in 1966. Its purpose is to affirm and continue to promote the integration of the scientist and the practitioner in training, research, and applied endeavors. Its members represent a diversity of interests and theoretical orientations across clinical psychology. The common bond of the membership is a commitment to empirical research and the ideal that scientific principles should play a role in training, practice, and establishing public policy for health and mental health concerns. SSCP has organizational affiliations with both the American Psychological Association (Section III of Division 12) and the Association for Psychological Science.”
- Other Information – Offers ten awards ranging from early career award, outstanding mentor award, outstanding student teacher award, and outstanding student clinician award.

- **American Society of Clinical Hypnosis**

- Website – <http://www.asch.net/>
- Mission Statement – “To provide and encourage education programs to further, in every ethical way, the knowledge, understanding, and application of hypnosis in health care; to encourage research and scientific publication in the field of hypnosis; to promote the further recognition and acceptance of hypnosis as an important tool in clinical health care and focus for scientific research; to cooperate with other professional societies that share mutual goals, ethics and interests; and to provide a professional community for those clinicians and researchers who use hypnosis in their work.”
- Publication – American Journal of Clinical Hypnosis
- Other Information – Offers certification in clinical hypnosis

### 1.6.2.2. Professional Journals

- **Clinical Psychology: Science and Practice**

- Website – [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1468-2850](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1468-2850)
- Published by – American Psychological Association, Division 12
- Description – “*Clinical Psychology: Science and Practice* presents cutting-edge developments in the science and practice of clinical psychology and related mental health fields by publishing scholarly articles, primarily involving narrative and systematic reviews as well as meta-analyses related to assessment, intervention, and service delivery.”

- **Journal of *Clinical Child and Adolescent Psychology***

- Website – <https://www.clinicalchildpsychology.org/JCCAP>
- Published by – American Psychological Association, Division 53
- Description – “It publishes original contributions on the following topics: (a) the development and evaluation of assessment and intervention techniques for use with clinical child and adolescent populations; (b) the development and maintenance of clinical child and adolescent problems; (c) cross-cultural and socio-demographic issues that have a clear bearing on clinical child and adolescent psychology in terms of theory, research, or practice; and (d) training and professional practice in clinical child and adolescent psychology, as well as child advocacy.”

- **American Journal of Clinical Hypnosis**

- Website – <http://www.asch.net/Public/AmericanJournalofClinicalHypnosis.aspx>
- Published by – American Society of Clinical Hypnosis
- Description – “The *Journal* publishes original scientific articles and clinical case reports on hypnosis, as well as reviews of related books and abstracts of the current hypnosis literature.”

## Key Takeaways

You should have learned the following in this section:

- Mental health professionals take on many different forms with different degree requirements, training, and the ability to prescribe medications.
- Telling others what we have done is achieved by joining professional societies and submitting articles to peer-reviewed journals.

## Section 1.6 Review Questions

1. Provide a general overview of the types of mental professionals and the degree, training, and ability to prescribe medications that they have.
2. Briefly outline professional societies and journals related to clinical psychology and related disciplines.

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## Module Recap

In Module 1, we undertook a relatively lengthy discussion of what abnormal behavior is by first looking at what normal behavior is. What emerged was a general set of guidelines focused on mental illness as causing dysfunction, distress, deviance, and at times, being dangerous for the afflicted and others around him/her. Then we classified mental disorders in terms of their occurrence, cause, course, prognosis, and treatment. We acknowledged that mental illness is stigmatized in our society and provided a basis for why this occurs and what to do about it. This involved a discussion of the history of mental illness and current views and trends.

Psychology is the scientific study of behavior and mental processes. The word *scientific* is key as psychology adheres to the strictest aspects of the scientific method and uses five main research designs in its investigation of mental disorders – observation, case study, surveys, correlational research, and experiments. Various mental health professionals use these designs, and societies and journals provide additional means to communicate findings or to be good consumers of psychological inquiry.

It is with this foundation in mind that we move to examine models of abnormality in Module 2.

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